

**MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH**  
DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-038551  
**5030** STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 149 Primary Registration District No. 1002 Registrar's No. \_\_\_\_\_

VS 300  
Rev. 4/59

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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF Otto W. Theel MEDICAL CERTIFICATION

1. <del>STATE OF IOWA</del> <b>OCT 19 1962</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
a. COUNTY <b>JACKSON</b>		a. STATE <b>IOWA</b>	b. COUNTY <b>POLK</b>
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>KANSAS CITY</b>		c. CITY OR TOWN <b>DES MOINES</b>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>3827 EAST GREGORY BLVD.</b>		d. STREET ADDRESS <b>3114 E. OVID AVENUE</b>	(If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ELIZABETH ALLEN</b>			4. DATE OF DEATH <b>OCTOBER 2 1962</b>
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>3/23/79</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>----</b>	9. AGE (last birthday) <b>83</b>
11a. FATHER'S NAME <b>THOMAS DAVIES</b>		11b. MOTHER'S MAIDEN NAME <b>JAKE JONES</b>	11c. NAME OF HUSBAND OR WIFE <b>WILLIAM ALLEN</b>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	17. INFORMANT <b>MRS. MAURICE TAYLOR</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastric Hemorrhage</u> DUE TO (b) <u>Duodenal Ulcer.</u> DUE TO (c) _____ Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Arteriosclerosis, Generalized.</u>			PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY STATE
21. I attended the deceased from <u>10-2-62</u> to <u>10-2-62</u> and last saw her/him alive on <u>10-2-62</u> Death occurred at <u>11:50 P.</u> m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Deceased or title) <u>Otto W. Theel M.D.</u>		22b. ADDRESS <u>4301 Main St. KCMo</u>	22c. DATE SIGNED <u>10-3-62</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>	23b. DATE <b>OCT. 3, 1962</b>	23c. NAME OF CEMETERY OR CREMATOR <b>GLENDALE CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>DES MOINES IOWA</b>
24. FUNERAL DIRECTOR <b>D.W. NEWCOMER'S SONS</b>		25. DATE RECD. BY LOCAL REG. <u>10-4-62</u>	26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>

USE BLACK INK OR TYPEWRITER RIBBON

W. Otto W. Steel, Jr.  
Room 5, 2nd Floor - 4301 Main Street  
1:30-5:00

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Thomas W. Hanson

Licensed Embalmer No. 4889  
P. O. Address Lathrop, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.